BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **THOMAS SPENCER, M.D.** Holder of License No. 41026 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-10-0471A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 10, 2011. Thomas Spencer, M.D. ("Respondent") appeared before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 41026 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-10-0471A after receiving a complaint regarding Respondent's care and treatment of patients DM, TC MR, LS, MG, RG, BW, RP, JH and GC. During the course of the investigation, patient SM's chart was also reviewed due to quality of care concerns.

4. The Board retained a Medical Consultant (MC), who reviewed the patients' charts and identified deviations from the standard of care in some of the charts as well as medical recordkeeping issues.

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Patient TC

5. On February 23, 2010, TC was admitted for a repeat C-section at 38 weeks gestation with an elevated blood pressure. TC's preoperative hemoglobin and hematocrit (H and H) was 11 and 33.

6. Following the C-section, the patient developed tachycardia and a slightly decreased H and H at 9.8 and 28.6. TC was taken to surgery and a spinal anesthetic was administered. TC became orthostatic and an examination under anesthesia (EUA) was carried out that was unsatisfactory.

7. TC coded and was intubated and resuscitated. General anesthesia was administered and Respondent carried out a laparotomy with dark bloody fluid in the abdomen and a uterus of 12 weeks size.

8. Vaginal packing was placed as a result of lacerations of the cervix noted from the tenaculum. TC was transferred to the intensive care unit (ICU) and general surgery consultation was obtained. TC's H and H was 7.6 and 22 after 2 units of uncross-matched PRBC's and 8L of crystalloid. An additional 4 unties of PRBC's were given and TC's H and H was 10 and 29.6. TC was subsequently transferred to another hospital for care.

Patient MR

9. On March 23, 2010, MR underwent a diagnostic laparoscopy with lysis of adhesions and removal of hemostatic clips from the pelvis. Respondent's operative note indicated that adhesions remained and that he saw small serosal defects, though no succus was visible and he felt that no small bowel injury was present. MR developed pain and nausea the following day and a right lower quadrant hematoma was noted. A CT scan showed a probable perforation and general surgery consultation was obtained. MR

was taken back to surgery with an 8 mm defect of the small bowel noted along with approximately 1L of succus present. An end-to-end anastomosis was carried out.

10. On March 31, 2010, MR developed pain and blood was present in her JP drain. MR returned to surgery and a 500 cc hematoma was evacuated. The hematoma reoccurred on April 6, 2010, which was treated with transfusion rather than surgery. On April 7, 2010, an enterocutaneous fistula was noted to possibly present since green discharge was noted to emanate from the incision. A CT scan did not show a direct communication with a loop of bowel below the incision. On April12, 2010, a fistulogram showed a collection in the transverse colon which was felt to likely be a colocutaneous fistula. Improvement was seen and MR was discharged on April 20, 2010.

11. During his Formal Interview, Respondent argued that the general surgeon did not find a hematoma in the case of the injury to the distal ilium. As a result, according to Respondent, there were minimal serosal defects noted on the original laparoscopy. He did acknowledge, however, that he did miss the 7-8 millimeter distal ilium injury.

Patient RG

12. RG discontinued progesterone after having taken it for three years with post-menopausal bleeding. A transvaginal ultrasound was obtained along with an endometrial biopsy. A dilation and curettage (D&C) and hysteroscopy was carried out on April 29, 2009 and a 1 cm polyp was noted. Pathology revealed proliferative endometrium. Prempro was prescribed, but RG continued to have bleeding. On June 25, 2009, RE underwent surgery and Respondent charted a 4x4x5 cm polyp.

13. In his response to the Board, Respondent stated that the base was cauterized and that he did a curettage; however, the operative report does not indicate that Respondent looked in after this.

14. Pathology from the second procedure did not reveal a polyp. On August 13, 2009, RG underwent IUD placement due to continued bleeding. In November 2009, Respondent attempted to remove the IUD, but he was unable to find the string. RG returned and the IUD was removed with aid of a hysteroscope. At that time, a cervical gouge was described and Respondent was unable to visualize the uterine cavity. By December 3, 2009, RG was tapering off of hormonal therapy and she was no longer spotting.

15. The standard of care when a patient develops complications following a C-section requires a physician to evaluate for possible causes and treat appropriately.

16. Respondent deviated from the standard of care by failing to evaluate TC further after the tachycardia was identified following the C-section.

17. The standard of care when small bowl injury involving the serosa and muscularis layer is identified or suspected requires a physician to perform a complete repair.

18. Respondent deviated from the standard of care by failing to repair the serosal defects when identified during MR'S procedure.

19. The standard of care for a patient with a prior medical history of taking unopposed estrogen requires a physician to evaluate the patient for the cause of the bleeding and treat appropriately to resolve the issue.

20. Respondent deviated from the standard of care by failing to ensure that the polyp was properly removed during RG's procedure.

21. TC suffered a cardiac arrest and reported further complications. MR suffered a bowel perforation and required subsequent surgical procedures. RG continued to have bleeding necessitating further intervention. In the case of TC, there was potential for patient death. There was potential for sepsis and death in the matter of MR.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) ("[f]ailing of refusing to maintain adequate records on a patient.").

ORDER

IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

ATED AND EFFECTIVE this 6th day of Oct., 2011.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

EXECUTED COPY of the foregoing mailed this 17th day of Oct, 2011 to:

Thomas Spencer, M.D.
Address of Record

ORIGINAL of the foregoing filed this 17th day of Oct, 2011 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

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Arizona Medical Board Staff